MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1952 — 0128

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: over 2 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 550 Revolution Street

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
d. STREET ADDRESS: 1550 Revolution St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
David	John	Bordley	2	28	1961

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	Negro		Sept. 7, 1908	52 yrs.	5	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Contractor	Newcastle, Delaware	U. S. A.

13. FATHER'S NAME: Charles Bordley
14. MOTHER'S MAIDEN NAME: Rosie Rumsey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	222-03-3953	Mrs. Ella M. Bordley	550 Revolution St. Havre de Grace

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Fulminating Pneumonia — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Influenza & Bronchiolitis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. **I certify** that (I) (this hospital) attended the deceased from 2/25, 1961, to 2/28, 1961, that (I) (we) last saw the deceased alive on 2/28 1961, and that death occured at ~~xxxx~~ M, from the causes and on the date stated above.

22a. SIGNATURE	ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED
George T. Stansbury, M.D.		3/2/61
22c. PHYSICIAN'S NAME (Type) George T. Stansbury	22d. ADDRESS 569 Revolution St. Havre de Grace, Md.	

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial	3-4-61	Berkley Cemetery	Darlington, Harford, Md.

24 FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Otelia J. Bullock, Havre de Grace, Md.	558 Lyric St.	MAR 7 '61	Arthur S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1963 CERTIFICATE OF DEATH

01923

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE de GRACE
c. LENGTH OF STAY IN 1b: 2 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HARFORD MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL FOREST HILL
d. STREET ADDRESS: ROCKS ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARY Middle ELIZABETH Last BROWNING

4. DATE OF DEATH: Month FEB. Day 20 Year 1961

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: AUG. 29, 1912

9. AGE (In years last birthday): 48 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (County & State, or foreign country): Alleghany Co, N. C.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: AMBROSE PUGH

14. MOTHER'S MAIDEN NAME: CORDELIA SARAH ROUPE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wars or dates of service): NO

16. SOCIAL SECURITY NO.: 220-07-5381

17. INFORMANT: JOSEPH K. BROWNING — Address: FOREST HILL, MD.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastasis from ca breast.
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour e.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Oct, 1953, to ....., 19....., that (I) (we) last saw the deceased alive on Feb ruary 20 1961, and that death occured at 1:15A.M. from the causes and on the date stated above.

22a. SIGNATURE: Wm. L. Brenden M.D.

22b. DATE SIGNED

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/22/1961

23c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens

23d. LOCATION (City, town or county) (State): Bel Air Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Charles E. Kurtz

ADDRESS: Jarrettsville, Md

25a. REC'D BY REGISTRAR DATE: FEB 23 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Krantz

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1954 CERTIFICATE OF DEATH

01930

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural-Whiteford
c. LENGTH OF STAY IN 1b: 11 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Pa. — b. COUNTY: York
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural- Delta
d. STREET ADDRESS: R.D.#1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

75X-3

3. NAME OF DECEASED (Type or print): First Middle Last: LAURENCE ELLSWORTH BUCHANAN

4. DATE OF DEATH: Month Day Year: Feb. 20, 1961

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	Negro		June 2,1895	65 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Janitor	Civil Service	Whiteford, Md.	USA

13. FATHER'S NAME: William G. Buchanan

14. MOTHER'S MAIDEN NAME: Nellie Coleman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): Yes — WWI

16. SOCIAL SECURITY NO.: 218-07-8073

17. INFORMANT Address: Clifford Buchanan, Whiteford, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocardial Failure — INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Cor Pulmonare
DUE TO (c): Chronic Emphysema

527.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. **I certify** that (I) (this hospital) attended the deceased from ..... 1959 to Feb 20, 1961, that (I) (we) last saw the deceased alive on Feb 17 1961, and that death occured at .....M, from the causes and on the date stated above.

22a. SIGNATURE: Josiah A. Hunt M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2/21/61

22c. PHYSICIAN'S NAME (Type): Josiah A. Hunt

22d. ADDRESS: Delta, Pa.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial	2-24-1961	Mt. Zion	Delta, York Co., Pa.

24 FUNERAL DIRECTOR'S SIGNATURE: John M. Watkins — ADDRESS: Delta, Pa.

25a. REC'D BY REGISTRAR DATE: FEB 24 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

Improvement Failure
for Delaware
Chinese Employees

Item 18 Film 288
5-31-61 ams

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

19[illegible] MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01031

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 Hours after death. If any [illegible] is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1. PLACE OF DEATH
a. COUNTY: Harford
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewood
c. LENGTH OF STAY IN 1b: 6 yrs.,
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Edgewood
d. STREET ADDRESS: 1 Emmorton
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EDGAR Middle L. Last CHAPPELL

4. DATE OF DEATH: Month February Day 20 Year 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June, 12, 1912

9. AGE (In years last birthday): 48 yrs.

IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic

10b. KIND OF BUSINESS OR INDUSTRY: Auto

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.,

13. FATHER'S NAME: James Chappell

14. MOTHER'S MAIDEN NAME: Linnie Cox

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): no

16. SOCIAL SECURITY NO.: 230-05-2756

17. INFORMANT Address: Mrs., Elza C. Chappell Edgewood, Maryland.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Aspiration of Gastric Contents due to Fatty Liver and Cirrhosis.
DUE TO (b):
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

5 810

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Petty M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type): Charles S. Petty, M.D.

Address (Street, city, town, or county)

DATE SIGNED: 2/21/61

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal

22b. DATE THEREOF: Feb. 23, 1961

22c. NAME OF CEMETERY OR CREMATORY: Vaughan-Gwynn F.H.,

22d. LOCATION (City, town or country) (State): Galax Virginia

23. FUNERAL DIRECTOR: Howard K. McCrum Jr.

ADDRESS: Abingdon, Maryland.

24a. REC'D BY REGISTRAR DATE FEB 24 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1956 01932

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hamed Grace
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D/H Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rising Sun Rural
d. STREET ADDRESS: 0 7X-2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Lewis Middle Asa Last Coulson

4. DATE OF DEATH: Month February Day 22 Year 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2/22/1912

9. AGE (In years last birthday): 49 yrs. IF UNDER 1 YEAR: Months, Days. IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Steel Worker

10b. KIND OF BUSINESS OR INDUSTRY: Wiley-Construction

11. BIRTHPLACE (State or foreign country): Penn.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Eli Coulson

14. MOTHER'S MAIDEN NAME: Fannie Rambo

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No

16. SOCIAL SECURITY NO.: 222-09-6911

17. INFORMANT: Mrs. Alice Reed Coulson Address: North East Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Fracture cervical vertebra — INTERVAL BETWEEN ONSET AND DEATH: -

910.3

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Steel beam dropped on head

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour 11 a.m. p.m. 2-22-61

20d. INJURY OCCURRED While at work ☒ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Wiley Const.

20f. (City or town) Co. Port (County) Cecil (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer M.D.

EXAMINER'S NAME (Type): Gerald C Palmer M.D.

CHIEF MEDICAL EXAMINER ☐ Bel Air, Md

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

DATE SIGNED: 2-22-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2/26/1961

22c. NAME OF CEMETERY OR CREMATORY: West Nottingham Cem.

22d. LOCATION (City, town, or country): Colora (State) Md.

23. FUNERAL DIRECTOR: Vernon E. McMullen ADDRESS: Rising Sun Md.

24a. REC'D BY REGISTRAR DATE: FEB 27 '61

24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent; prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME 5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1957 — Reg. Dist. No. 11455

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
c. LENGTH OF STAY IN 1b: 4 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Convalescent Home

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Aberdeen
d. STREET ADDRESS: 1 Paradise Road.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Emily — Middle Francis — Last Cullum

4. DATE OF DEATH: Month February — Day 14 — Year 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: November 5, 1874
9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — M.n

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Norah Franklin Simpson
14. MOTHER'S MAIDEN NAME: Emma V. Levey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO:
17. INFORMANT Address: Harford Convalescent Home, Rt. #1, Bel Air, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Coronary thrombosis	?
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)		
DUE TO (c)	Chronic cardio-vascular disease	?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from Sept. 16, 1956, to February 14, 1961, that I last saw the deceased alive on Feb. 13, 1961, and that death occurred at 6:00A.M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Willard P. Hudson M.D — ADDRESS (Street, city or town, state): Forest Hill, Md. — DATE SIGNED: February 14, 1961

PHYSICIAN'S NAME (Type): Willard P. Hudson, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/16/1961
22c. NAME OF CEMETERY OR CREMATORY: Babers Cemetery
22d. LOCATION (City, town, or county) (State): Aberdeen, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: John G. Tarring — Tarring Funeral Home — Aberdeen Maryland
24a. REC'D BY REGISTRAR DATE: FEB 17 '61
24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1958

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: HARFORD
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE de GRACE
c. LENGTH OF STAY IN 1b: 14 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HARFORD MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perryville
d. STREET ADDRESS: RFD #1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Milton; Middle: M; Last: Cully Sr.

4. DATE OF DEATH: Month: February; Day: 25; Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 1-23-1883

9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Telegraph Operator

10b. KIND OF BUSINESS OR INDUSTRY: Rail Road

11. BIRTHPLACE (County & State, or foreign country): Penna

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: George Cully

14. MOTHER'S MAIDEN NAME: Mary Strigel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 216-09-8208

17. INFORMANT: John W. Cully Jr., Address: Perryville, Md

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Antein Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: minutes
DUE TO (b): Advanced arteriosclerotic cardio-vascular disease. — years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Saccular Aneurysm — aorta bifurcation

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m.; Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Feb. 11, 1961 to ....., 19....., that (I) (we) last saw the deceased alive on Feb. 25 1961, and that death occured at 2 P.M. from the causes and on the date stated above.

22a. SIGNATURE: W. H. Sadowsky M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2/25/61

22c. PHYSICIAN'S NAME (Type): W. H. SADOWSKY

22d. ADDRESS: 504 Lewis St. Havre de Grace Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2-28-1961

23c. NAME OF CEMETERY OR CREMATORY: St. Marks Cem.

23d. LOCATION (City, town or county) (State): Perryville, Md. Rural

24. FUNERAL DIRECTOR'S SIGNATURE: Vera Patterson & Son, Perryville, Md.

ADDRESS

25a. RECD BY REGISTRAR DATE: FEB 28 61

25b. REGISTRAR'S SIGNATURE: Clarkson S. Fisher

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1959 **CERTIFICATE OF DEATH** 01955

1. PLACE OF DEATH
a. COUNTY: HARFORD
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE de GRACE
c. LENGTH OF STAY IN 1b: 8 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HARFORD MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE de GRACE
d. STREET ADDRESS: 419 LODGE ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: OSCINA; Middle: ADDIE; Last: DUTTON

4. DATE OF DEATH: Month: FEB.; Day: 25; Year: 1961

5. SEX: F

6. COLOR OR RACE: N.

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☑ **DIVORCED** ☐

8. DATE OF BIRTH: Aug. 26, 1889

9. AGE (In years last birthday): 71 yrs. IF UNDER 1 YEAR: Months: 5; Days: 29. IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: Private Family

11. BIRTHPLACE (County & State or foreign country): Rockingville, MD.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: FRED ALLISON

14. MOTHER'S MAIDEN NAME: JULIA LARUE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 212-32-3265

17. INFORMANT: Mrs. Adelle Wainwright, Havre de Grace, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO (b): Arterio sclerotic Heart disease — 3 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Anemia Pneumonia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 2/12/61 to 2/25/61, that (I) (we) last saw the deceased alive on 2/25/61, and that death occured at 1:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Wm L. Wilson M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3-1-61

23c. NAME OF CEMETERY OR CREMATORY: Union Methodist Cem

23d. LOCATION (City, town or county) (State): Aberdeen, Harford Co. Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Otelia J. Bullock, Havre de Grace Md.

ADDRESS: 553 Lewis St.

25a. REC'D BY REGISTRAR DATE FEB 28 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed ... hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1960 0190

1 PLACE OF DEATH
a. COUNTY HARFORD MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE de GRACE
c. LENGTH OF STAY IN 1b 7 DAYS
d NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION HARFORD MEMORIAL HOSPITAL

2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE MARYLAND b. COUNTY CECIL ✓
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RISING SUN
d STREET ADDRESS CTX
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First ANNA Middle IDA Last FELTMAN
4. DATE OF DEATH Month FEB. Day 3 Year 1961

5 SEX F
6 COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH 6-12-1883
9. AGE (In years last birthday) 77 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b KIND OF BUSINESS OR INDUSTRY Ret.
11. BIRTHPLACE (State or foreign country) MICHIGAN
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME FREITAG Unknown

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO
16 SOCIAL SECURITY NO 472-01-7273D
17 INFORMANT Carl D. Feltman Address Rising Sun, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident — INTERVAL BETWEEN ONSET AND DEATH 5 days
DUE TO (b) Hypertension — 2 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Hour o. m. p. m. Month Day Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from 1/5 19 61 to 2/3 19 61, that (I) (we) last saw the deceased alive on 2/2 19 61, and that death occurred at 4:55 AM from the causes and on the date stated above

22a. SIGNATURE Neil Taylor M.D
ATTENDING PHYS ☑ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED 2/3/61
22c PHYSICIAN'S NAME (Type) Neil Taylor Jr
22d. ADDRESS Rising Sun, Md

23a BURIAL, CREMATION REMOVAL (Specify) Burial
23b DATE THEREOF 2-7-1961
23c NAME OF CEMETERY OR CREMATORY Brookview Cem.
23d LOCATION (City, town, or county) Rising Sun, (State) Md.

24 FUNERAL DIRECTOR'S SIGNATURE Vernon E. McMullen
ADDRESS Rising Sun Md.
25a. REC'D BY REGISTRAR DATE FEB 7 '61
25b REGISTRAR'S SIGNATURE Ann S. Krauss

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01957

1961

1. PLACE OF DEATH
a. COUNTY: Harford
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perryman
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): J.O. Mitchell Bro. Canning Co.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perryman
d. STREET ADDRESS: c/o J.O. Mitchell Bro. Canning Co.
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Joseph Middle: J Last: Fisher

4. DATE OF DEATH: Month: February Day: 5 Year: 19 61

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3/7/1881

9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS: Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Canning Co.

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Fisher

14. MOTHER'S MAIDEN NAME: Harriett Wilmore

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no

16. SOCIAL SECURITY NO.:

17. INFORMANT: Olevia A Stansbury Address: Perryman, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Arteriosclerotic C.V. disease — INTERVAL BETWEEN ONSET AND DEATH:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): 422.1

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Herrick C Palmer M.D

EXAMINER'S NAME (Type): Herrick C Palmer M.D

CHIEF MEDICAL EXAMINER ☐ Bel Air, Md

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

DATE SIGNED: 2-5-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2/9/61

22c. NAME OF CEMETERY OR CREMATORY: Union M.E. Cemetery

22d. LOCATION (City, town, or country) (State): Aberdeen, Maryland

23. FUNERAL DIRECTOR: John T. Canning ADDRESS: Aberdeen, Maryland

24a. REC'D BY REGISTRAR DATE: FEB 10 '61

24b. REGISTRAR'S SIGNATURE: Arthur L. Frank

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any ... Please ... the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1962 — 01958

1. PLACE OF DEATH a. COUNTY: Harford — MARYLAND — b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace — c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission) a. STATE: Md. — b. COUNTY: Cecil — c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Port Deposit — d. STREET ADDRESS: Box 74 — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Eva — Middle: — Last: Gabbert

4. DATE OF DEATH: Month: 2 — Day: 17 — Year: 1961

5. SEX: Female — **6. COLOR OR RACE**: White — **7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐ — **8. DATE OF BIRTH**: April 1, 1919 — **9. AGE** (In years last birthday): 42 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House-wife — **10b. KIND OF BUSINESS OR INDUSTRY**: — **11. BIRTHPLACE** (County & State, or foreign country): W. Va — **12. CITIZEN OF WHAT COUNTRY?**: U S A

13. FATHER'S NAME: John Holbrook — **14. MOTHER'S MAIDEN NAME**: Ella Miller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — **16. SOCIAL SECURITY NO.**: 216-22-4726 — **17. INFORMANT**: Paul Gabbert Husband — Address: Port Deposit, Md

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Bacterial Endocarditis — INTERVAL BETWEEN ONSET AND DEATH: 3 months

DUE TO (b): Uremia & Chronic Nephritis — 6 months

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — **19. WAS AUTOPSY PERFORMED?** YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Jan 1, 1961, to 2-17, 1961, that (I) (we) last saw the deceased alive on 2-17, 1961, and that death occured at 5:35 P.M. from the causes and on the date stated above

22a. SIGNATURE: [signature] M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 3/13/61

22c. PHYSICIAN'S NAME (Type): G.H. Richards Jr. — 22d ADDRESS: Port Deposit, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal & Burial 2-18-1961 — 23b. DATE THEREOF — 23c. NAME OF CEMETERY OR CREMATORY: Woodlawn Cemetery — 23d. LOCATION (City, town or county) (State): Auto, West Virginia

24. FUNERAL DIRECTOR'S SIGNATURE: Lee A. Patterson & Son — ADDRESS: Perryville, Md. — 25a. REC'D BY REGISTRAR DATE: FEB 20 '61 — 25b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1963 CERTIFICATE OF DEATH

01953

1 PLACE OF DEATH
a. COUNTY HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE de GRACE
c. LENGTH OF STAY IN 1b 5 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Memorial Hosp.

2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE Maryland b. COUNTY Cec. 1
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Port Deposit
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First: Woodward Middle: A Last: Gatchell

4. DATE OF DEATH Month: February Day: 16 Year: 1961

5. SEX: MALE
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov. 26, 1886
9. AGE (In years last birthday) 74 yrs — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Gardner
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (State or foreign country): Pennsylvania
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jeremiah Gatchell
14 MOTHER'S MAIDEN NAME: Elizabeth Adams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 212-32-0633
17. INFORMANT Address: Mrs. K. Gatchell, Port Deposit, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocard. fib. & fib.
DUE TO (b) Angina Pectoris
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH: (a) 3 hrs (b) 5 yrs

420.2
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from 1-17 1955, to 2-16 1961, that (I) (we) last saw the deceased alive on 2-15 1961, and that death occurred at 5:30 P.M. from the causes and on the date stated above

22a SIGNATURE G. H. Richards, Jr. M.D
ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED 2/16/61
22c PHYSICIAN'S NAME (Type) G. H. Richards, Jr.
22d ADDRESS Port Deposit, Maryland

23a BURIAL, CREMATION, REMOVAL (Specify) Burial
23b DATE THEREOF 2-19-61
23c NAME OF CEMETERY OR CREMATORY West Nottingham Cem.
23d LOCATION (City, town, or county) Colora (State) Md

24 FUNERAL DIRECTOR'S SIGNATURE Julia Patterson & Son ADDRESS Perryville, Md.
25a REC'D BY REGISTRAR DATE FEB 20 '61
25b REGISTRAR'S SIGNATURE Arthur S. Krause

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 1SM 9/59

4. 1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1964 — 01940

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE DE GRACE
c. LENGTH OF STAY N 1b: 2HRS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HARFORD MEMORIAL HOSP.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE DE GRACE
d. STREET ADDRESS: 308 Wilson St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MARY — Middle: A — Last: GENTRY (nee Frazzitta)

4. DATE OF DEATH: Month: FEBRUARY — Day: 17 — Year: 1961

5. SEX: FEMALE — 6. COLOR OR RACE: White — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF B.TH: Mar.1,1905 — 9. AGE (In years last birthday): 55 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Presser — 10b. KIND OF BUSINESS OR INDUSTRY: Laundry — 11. BIRTHPLACE (County & State, or foreign country): Italy — 12. CITIZEN OF WHAT COUNTRY?: U.S.A.,

13. FATHER'S NAME: Frank Albione — 14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no — 16. SOCIAL SECURITY NO.: 213-10-9917 — 17. INFORMANT: Thomas Gentry — Address: Havre de Grace Md.,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO (b): Chronic cardiac decompensation

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Coronary thrombosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED: While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 2-17, 1961 to 2-17, 1961, that (I) (we) last saw the deceased alive on 2-17 1961, and that death occured at 11:45 A.M., from the causes and on the date stated above.

22a. SIGNATURE: E J Simon — MD — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 2-17-61

22c. PHYSICIAN'S NAME (Type): E J SIMON — 22d. ADDRESS: HAVRE DE GRACE, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: Feb.22,1961 — 23c. NAME OF CEMETERY OR CREMATORY: Angel Hill — 23d. LOCATION (City, town or county) (State): Havre de Grace,Harford, Md.,

24. FUNERAL DIRECTOR'S SIGNATURE: Edward L McGraw Jr — ADDRESS: Abingdon,Md., — 25a. REC'D BY REGISTRAR DATE: FEB 24 '61 — 25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

I

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1965 Reg. Dist. No. 0194

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural * Street
c. LENGTH OF STAY IN 1b: 57 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural -Street
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First VERNON Middle ELMER Last GRIER
4. DATE OF DEATH: Month February Day 24 Year 1961
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: July 9,1903
9. AGE (In years last birthday): 57 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tile setter
10b. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (State or foreign country): Street, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Elmer L. Grier
14. MOTHER'S MAIDEN NAME: Josephine Butler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 577-14-0038
17. INFORMANT: Miss Margie Grier, Address 3821 Belair Rd. Balto. 13, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): Coronary Occlusion
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 5 0 2 . 0
DUE TO (c): Chronic Emphysema & Bronchitis

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Post operative — Cholecystectomy
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 1960, to Feb 27, 1961, that I last saw the deceased alive on Feb 23, 1961, and that death occurred at 2:30 A M, from the causes and on the date stated above.
ACTUAL SIGNATURE: Josiah A Hunt M.D.
ADDRESS (Street, city or town, state): Delta Pa
DATE SIGNED: 2/25/61
PHYSICIAN'S NAME (Type): Josiah A. Hunt

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Feb. 27, 1961
22c. NAME OF CEMETERY OR CREMATORY: Deer Creek Meth.
22d LOCATION (City town, or county) (State): Forest Hill, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John H. Hardenia
ADDRESS: Delta, Penna.
24a. REC'D BY REGISTRAR DATE MAR 1 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after [illegible] by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in [illegible] director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 4

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1966 CERTIFICATE OF DEATH

Reg. Dist. No. 01942

1. PLACE OF DEATH
a. COUNTY: Harford
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewood
c. LENGTH OF STAY IN 1b: Lifetime
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewood
d. STREET ADDRESS: Willoughby Beach
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Frederick; Middle: William; Last: Gunther

4. DATE OF DEATH: Month: Feb.; Day: 22; Year: 19 61

5. SEX: male

6. COLOR OR RACE: white.

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 12, 1874

9. AGE (In years last birthday): 86 yrs

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stationary Fireman

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Govt.,

11. BIRTHPLACE (State or foreign country): Edgewood, Maryland.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.,

13. FATHER'S NAME: Frederick Gunther

14. MOTHER'S MAIDEN NAME: Emka Behrends

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Rosa M. Gunther — Address: Edgewood Maryland.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arterial sclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs
DUE TO
(b):
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2-1-59, to 2-22-64, that I last saw the deceased alive on 2-22-64, and that death occurred at 1130 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Fred O Hodus M.D. — ADDRESS (Street, city or town, state): Edgewood Md — DATE SIGNED: 2-22-61

PHYSICIAN'S NAME (Type): Fred O. Hodus — Edgewood Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Feb. 26, 1961

22c. NAME OF CEMETERY OR CREMATORY: Trinity Lutheran

22d. LOCATION (City, town, or county) (State): Joppa, Harfprd, Md.,

23. FUNERAL DIRECTOR'S SIGNATURE: Howard L. Tomes Jr — ADDRESS: Abingdon Maryland

24a. REC'D BY REGISTRAR DATE: FEB 28 '61

24b. REGISTRAR'S SIGNATURE: Carlton L. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

M

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DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the items are unknown, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1961 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01943

1. PLACE OF DEATH
a. COUNTY Howard — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City
c. LENGTH OF STAY IN 1b 40 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Md. Sol. Par.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE Md. b. COUNTY Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City
d. STREET ADDRESS Mountain Rd. e. 15 RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First: Lottie Middle: Hackett Last:
4. DATE OF DEATH Month: Feb Day: 16 Year: 1961

5. SEX F
6. COLOR OR RACE C
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH Oct 11-1869
9. AGE (In years last birthday) 91 yrs.
IF UNDER 1 YEAR Months: Days: IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired
10b. KIND OF BUSINESS OR INDUSTRY At Home
11. BIRTHPLACE (State or foreign country) Harford Co, Md
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Augusta Hanson
14. MOTHER'S MAIDEN NAME UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs Evelyn Dorsey Address 24 Churchville Road Bel Air, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH 4 years
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and in my opinion death resulted from. Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE George C Palmer M.D
EXAMINER'S NAME (Type) George C Palmer MD
CHIEF MEDICAL EXAMINER ☐ Balto, Md
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑
Address (Street, city, town, or county)
DATE SIGNED 2-16-61

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Feb 18/61
22c. NAME OF CEMETERY OR CREMATORY Mountain Methodist
22d. LOCATION (City, town, or country) (State) Joppa Harford Md.

23. FUNERAL DIRECTOR Joseph T Foster ADDRESS Bel Air Md
24a. REC'D BY REGISTRAR DATE FEB 20 '61
24b. REGISTRAR'S SIGNATURE Carlton E. Hanna

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

0194

1968

1. PLACE OF DEATH a. COUNTY Harford MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace
c. LENGTH OF STAY IN 1b 6 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE Maryland b. COUNTY Harford
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace 2
d. STREET ADDRESS 550 Alliance
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Eliza Middle J. Last Haskins
4. DATE OF DEATH Month February Day 3 Year 1961

5 SEX Female
6 COLOR OR RACE Col
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH Jan. 29, 1882
9. AGE (In years last birthday) 79 yrs.
IF UNDER 1 YEAR Months 1 Days 2 IF UNDER 24 HRS Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Housewife
11 BIRTHPLACE (State or foreign country) Richmond, Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Adolph Jones
14. MOTHER'S MAIDEN NAME Jane (No Record of last name)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service)
16 SOCIAL SECURITY NO None.
17 INFORMANT Mr. Calvin Haskins Address 550 Alliance St. Havre de Grace, Md.

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MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH

232

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (b)

DUE TO (c) Generalized Arteriosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — Pulmonary Emphysema

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from Jan. 9, 1961 to Feb. 3, 1961, that (I) (we) last saw the deceased alive on 3 Feb 1961 and that death occurred at 9 A.M. from the causes and on the date stated above.

22a SIGNATURE George T. Stansbury, M.D.
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED 2/4/61
22c PHYSICIAN'S NAME (Type) George T Stansbury
22d. ADDRESS 569 Revolution St, Havre de Grace, Md.

23a BURIAL, CREMATION, REMOVAL (Specify) Burial
23b DATE THEREOF Feb. 8, 1961
23c NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery
23d LOCATION (City, town, or county) (State) Aberdeen, Harford, Md.

24. FUNERAL DIRECTOR'S SIGNATURE Eleanor E Bullock ADDRESS Havre de Grace, Md.
25a RECD BY REGISTRAR DATE FEB 8 '61
25b. REGISTRAR'S SIGNATURE Arthur J. Krauss

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours [illegible] Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1969 CERTIFICATE OF DEATH

019

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre-de-Grace
c. LENGTH OF STAY N 1b: 12 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Md.
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest to): Port Deposit
d. STREET ADDRESS: 83 N. Main.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Michael — Middle: Joseph — Last: Hipkins

4. DATE OF DEATH: Month: 2 — Day: 3 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARR.ED** ☐ **WIDOWED** ☐ **DIVORCED** ☐ (Never Married)

8. DATE OF B.RTH: Jan. 24, 1961

9. AGE (In years last birthday): yrs 12 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Mn.

10a. USUAL OCCUPAT ON (Give k nd of work done during most of working life, even if retired):

10b KIND OF BUSINESS OR INDUSTRY:

11 B RTHPLACE (County & State, or fore gn country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U S A

13. FATHER'S NAME: Hipkins, Walter. H.

14 MOTHER'S MAIDEN NAME: Dolores A. Maloy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOC AL SECURITY NO:

17. INFORMANT Address: Walter H. Hipkins, Port Deposit, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): 754.5 Congenital heart disease

DUE TO (b): Pneumonia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART I.. OTHER SIGNIF.CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE COND.TION GIVEN N PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACC DENT WAS UNDERLYING ☐ OR CONTRIBUT.NG ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part I. of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF NJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from ... 19 , to 2/1 19 61 that (I) (we) last saw the deceased alive on 2/3 19 61, and that death occured at 4 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Theodore H. Kaiser M.D.

22b. DATE SIGNED

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type): Theodore H. Kaiser, M.D.

22d. ADDRESS: Havre De Grace, Md.

23a. BURIAL, CREMATION REMOVAL (Specify): Burial

23b. DATE THEREOF: 2-7-1961

23c. NAME OF CEMETERY OR CREMATORY: Hopewell Cemetery

23d. LOCATION (City, town or county) (State): Port Deposit, Md. Rural

24 FUNERAL DIRECTOR'S SIGNATURE: Lee A. Patterson Sr.

ADDRESS: Perryville, Md

25a. REC'D BY REGISTRAR DATE: FEB 8 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1970 CERTIFICATE OF DEATH

01946

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE DE GRACE
c. LENGTH OF STAY IN 1b: 1½ DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HARFORD MEMORIAL HOSP.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL BEL AIR
d. STREET ADDRESS:
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Effie — Middle: W — Last: Johnson

4. DATE OF DEATH: Month: February — Day: 27 — Year: 1961

5. SEX: FEMALE

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: May 28 1909

9. AGE (In years last birthday): 51 yrs.
IF UNDER 1 YEAR — Months: — Days: — IF UNDER 24 HRS. — Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clothes

10b. KIND OF BUSINESS OR INDUSTRY: Presser

11. BIRTHPLACE (County & State, or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: MAJOR Willis

14. MOTHER'S MAIDEN NAME: Julia Edwards

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 213-20-2711

17. INFORMANT: Mrs. Irene Billings (Dudley Johnson) — Address: Bel Air Md RD2 Box 54A

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Shock — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Intestinal destruction
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Carcinomatosis from stomach

151X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year: 19 — **20d. INJURY OCCURRED** While at work ☐ Not While at work ☐ — **20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.) — **20f.** (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ..... 19..... to ..... 19....., that (I) (we) last saw the deceased alive on ..... 19..... and that death occured at 1:50 A.M. from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED:
22c. PHYSICIAN'S NAME (Type):
22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: March 1 61
23c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens
23d. LOCATION (City, town or county) (State): Bel Air Harford Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Joseph W. Foster
ADDRESS: W. Broadway & Williams St. Bel Air, Maryland

25a. REC'D BY REGISTRAR DATE: MAR 1 '61
25b. REGISTRAR'S SIGNATURE: Clifton S. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1971 CERTIFICATE OF DEATH

019+7

1. PLACE OF DEATH
a. COUNTY Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace
c. LENGTH OF STAY IN 1b 33 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 554 Alliance Street

2. USUAL RESIDENCE (Where deceased lived, If institution: Res dence before admission)
a. STATE Maryland b. COUNTY Harford
c. CITY OR TOWN (If outside corporate l mits, write RURAL and give nearest town) Havre de Grace
d. STREET ADDRESS 554 Alliance St. — IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Mable Middle: J. Last: Joyner

4. DATE OF DEATH Month: 2 Day: 2 Year: 1961

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: March 15, 1899

9. AGE (In years last birthday): 61 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working l fe, even f retired): Factory worker

10b. KIND OF BUSINESS OR INDUSTRY: Ford Cannery

11. BIRTHPLACE (County & State, or foreign country): Holly Hill So. Carolina

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Thomas Jenkins

14. MOTHER'S MAIDEN NAME: Betty Oliver

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)

16. SOCIAL SECUR.TY NO.: 230-03-2479

17. INFORMANT: Mrs Frances Cromwell Address 554 Alliance St Havre de Grace, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH

420.0

DUE TO (b) Arteriosclerotic Heart disease = Cerebral Sclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c) Generalized Arteriosclerosis

PART II OTHER S GN FICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM.NA. DISEASE CONDITION GIVEN N PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLY NG L. OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED (Enter nature of in ury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1-4, 1961 to 2-2, 1961, that (I) (we) last saw the deceased alive on 2-1, 1961, and that death occured at 4:00 P M, from the causes and on the date stated above.

22a. SIGNATURE George T Stansbury, M D

22c. PHYSICIAN'S NAME (Type) George T. Stansbury

ATTENDING PHYS. ☑ MED. D RECTOR ☐ STAFF PHYS. ☐

22d. ADDRESS 529 Revolution St Havre de Grace, Md

22b. DATE SIGNED 2/4/61

23a. BURIAL, CREMAT.ON, REMOVAL (Specify) Burial

23b. DATE THEREOF 2/5/61

23c. NAME OF CEMETERY OR CREMATORY St. James Cemetery

23d. LOCATION (City, town or county) (State) Havre de Grace Md

24 FUNERAL DIRECTOR'S S.GNATURE Clifford Bullock ADDRESS Havre de Grace

25a. REC'D BY REGISTRAR DATE FEB 8 '61

25b. REGISTRAR'S SIGNATURE Arthur S. Krauss

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1972 CERTIFICATE OF DEATH

Reg. Dist. No. 0194

1. PLACE OF DEATH — COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 232 S. Phila. Blvd.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
d. STREET ADDRESS: 232 S. Phila. Blvd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHRISTIAN Middle J. Last KALMBACKER
4. DATE OF DEATH: Month February Day 15 Year 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug. 11, 1883
9. AGE (In years last birthday): 77 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter (Ret.)
10b. KIND OF BUSINESS OR INDUSTRY: Painting
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John George Kalmbacker
14. MOTHER'S MAIDEN NAME: Barbara Anna Schantz
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Mary L. Kalmbacker, Aberdeen, Md. Address 232 S. Phila. Blvd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CEREBRO VASCULAR ACCIDENT — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks
DUE TO (b): CEREBRAL THROMBOSIS — " "
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Generalised Arterio Sclerosis — 2 Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from Oct, 1960 to February, 1961, that I last saw the deceased alive on Feb 13, 1961, and that death occurred at 4:00 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Andre Weiss M.D.
ADDRESS (Street, city or town, state): 114 W. Bel Air Ave.
DATE SIGNED:
PHYSICIAN'S NAME (Type): Andre Weiss, M.D. Aberdeen, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/17/61
22c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens,
22d. LOCATION (City, town, or county) (State): Bel Air, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE: John T. Tarring
ADDRESS: Tarring Funeral Home Aberdeen, Md.
24a. REC'D BY REGISTRAR DATE: FEB 20 '61
24b. REGISTRAR'S SIGNATURE: Clinton S. Travers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
ISM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1973 CERTIFICATE OF DEATH

Reg. Dist. No. 019-13

1. PLACE OF DEATH
a. COUNTY: Harford. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace.
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Memorial Hospt.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
d. STREET ADDRESS: 307 S. Union Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Robert Middle H. Last Kent
4. DATE OF DEATH: Month Feb. Day 3 Year 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 1st, 1886
9. AGE (In years last birthday): 74 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ballistician (Retired)
10b. KIND OF BUSINESS OR INDUSTRY: Govt. A.P.G. Md.
11. BIRTHPLACE (State or foreign country): Meriden Conn.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Silas William Kent
14. MOTHER'S MAIDEN NAME: Mary Chapman

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown): Yes (If yes, give war or dates of service): War I.
16. SOCIAL SECURITY NO.:
17. INFORMANT: Long Island, N.Y. Address: 85 Windham Rd. Mrs. Sidney Grant, Rockville Center

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Gastro-intestinal Haemorrhage — Terminal
DUE TO (b): Hypoprothrombinemia — 1 year
DUE TO (c): Cirrhosis of liver — 2 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

581.0

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerotic Heart Disease

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from 1948, 19__ to 2-3-, 1961, that I last saw the deceased alive on Feb 2nd, 1961, and that death occurred at 6:32 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Peter P. Rothman, M.D. ADDRESS (Street, city or town, state): 8 Law St. Aberdeen, Md. DATE SIGNED: 2/3/61
PHYSICIAN'S NAME (Type): Peter P. Rothman, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 2/3/1961
22c. NAME OF CEMETERY OR CREMATORY: Greenmount Crematory
22d. LOCATION (City, town, or county) (State): Balto. Maryland

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: John G. Tarring Funeral Home Aberdeen, Maryland.
24a. REC'D BY REGISTRAR DATE: FEB 7 '61
24b. REGISTRAR'S SIGNATURE: Caroline L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The filing of this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1974 — Reg. Dist. No. 1950

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Street
c. LENGTH OF STAY IN 1b: 60 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Md. — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural- Street
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First HUGH — Middle M. — Last LAIRD

4. DATE OF DEATH: Month February — Day 10, — Year 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 20,1778

9. AGE (In years last birthday): 82 yrs
IF UNDER 1 YEAR: Months: Days: — IF UNDER 24 HRS: Hours: Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm Owner

10b. KIND OF BUSINESS OR INDUSTRY: Agri.

11. BIRTHPLACE (State or foreign country): Gatchelville,Pa.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Hugh M. Laird

14. MOTHER'S MAIDEN NAME: Mary Boyd

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO: 219-36-0755

17. INFORMANT: Mrs. May J. Laird, Address: Street, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Cerebral apoplexy — INTERVAL BETWEEN ONSET AND DEATH: 3 wk

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Generalized arteriosclerosis — 3 yr
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept, 1959, to 10 Feb, 1961, that I last saw the deceased alive on 10 February 61, and that death occurred at 10 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edwin W. Whiteford Jr M.D. — M.D. — ADDRESS (Street, city or town, state): Whiteford, Maryland — DATE SIGNED: 12 Feb 61

PHYSICIAN'S NAME (Type): Edwin W. Whiteford Jr., M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2-14-1961

22c. NAME OF CEMETERY OR CREMATORY: St. Ignatius

22d. LOCATION (City, town, or county) (State): Hickory, Harford Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John H. Harbeina — ADDRESS: Delta, Penna.

24a. REC'D BY REGISTRAR DATE: FEB 14 '61

24b. REGISTRAR'S SIGNATURE: Cathryn L. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1975 CERTIFICATE OF DEATH

Reg. Dist. No. 01951

1. PLACE OF DEATH
a. COUNTY: Harford — STATE: Maryland
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 84 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
d. STREET ADDRESS: 123 S. Union Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: G. — Last: Leffler

4. DATE OF DEATH: Month: 2/4/61 — Day — Year: 19

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11/24/1876

9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Gen. Pens. Citizens Nat. Bank

11. BIRTHPLACE (State or foreign country): Havre de Grace Md

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Albert Leffler

14. MOTHER'S MAIDEN NAME: Elizabeth Moseman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Mary F. Leffler — Address: 123 S. Union Ave. Havre de Grace Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Sudden
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 2-4, 19 61, to 2-4, 19 61, that I last saw the deceased alive on 2-3, 19 61, and that death occurred at 2:4 A. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward J. Simon M.D. — ADDRESS (Street, city or town, state): 201 S UNION AVE — DATE SIGNED:

PHYSICIAN'S NAME (Type): EDWARD J. SIMON HAVRE DE GRACE MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 2/7/61 — 22c. NAME OF CEMETERY OR CREMATORY: Angel Hill — 22d. LOCATION (City, town, or county) (State): Havre de Grace Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Thomas Lee Dr. — ADDRESS: Havre de Grace Md.

24a. REC'D BY REGISTRAR DATE: FEB 9 '61

24b. REGISTRAR'S SIGNATURE: Chas E. Howe

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: Before this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1976. CERTIFICATE OF DEATH

Reg. Dist. No. 01952

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural
c. LENGTH OF STAY IN 1b: 81 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: —

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Bel Air
d. STREET ADDRESS: Rural
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: William — Middle: Henry — Last: Magness
4. DATE OF DEATH: Month: Feb — Day: 20 — Year: 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct 20, 1879
9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (State or foreign country): Bel air Md
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Albert Magness
14. MOTHER'S MAIDEN NAME: Amanda Dewood Bel Air Md

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Walter Magness — Address: Benson Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): PNEUMONIA AND RENAL SHUT DOWN — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO
(b): ARTERIO-SCLEROTIC CARDIOVASCULAR DIS. — over 4 yrs.
DUE TO
(c): —

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 422.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): BPH

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): —
20c. TIME OF INJURY Hour: o. m. / p. m. — Month, Day, Year: — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): —
20f. (City or town) (County) (State): —

21. I certify that I attended the deceased from JUNE 22, 1957 to FEB 20, 1961, that I last saw the deceased alive on FEB 20, 1961, and that death occurred at 12:30 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Philip W. Heuman M.D. — ADDRESS (Street, city or town, state): 307 Hickory Ave — DATE SIGNED: FEB 22, 61
PHYSICIAN'S NAME (Type): PHILIP W. HEUMAN M.D. BEL AIR, MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-23-1961
22c. NAME OF CEMETERY OR CREMATORY: Mountain Christian
22d. LOCATION (City, town, or county): Joppa (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE: Litt Archer — ADDRESS: Benson Md
24a. REC'D BY REGISTRAR DATE: FEB 27 '61
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1977 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01958

1. PLACE OF DEATH
a. COUNTY: HARFORD
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE DE GRACE
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): PASSENGER CAR. PENN'A. R.R. STA.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: NEW YORK
b. COUNTY: LONG ISLAND
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): MANHASSET
d. STREET ADDRESS: 306 CRABAPPLE Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: LEO; Middle: KENNETH; Last: MAYER

4. DATE OF DEATH: Month: FEBRUARY; Day: 5; Year: 1961

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: NOV 13, 1897

9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ATTORNEY

10b. KIND OF BUSINESS OR INDUSTRY: ECONOMIST

11. BIRTHPLACE (State or foreign country): NEW YORK

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: SAMUEL MAYER

14. MOTHER'S MAIDEN NAME: ADELE KAUFMAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): UNK

16. SOCIAL SECURITY NO.: UNK

17. INFORMANT: JOYCE M. GOLDBERG, GLEN COVE, N.Y.
Address: 37 OAK LANE

I

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ACUTE CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: INSTANT
DUE TO (b): CORONARY INSUFFICIENCY — 6 1/2 YRS
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): NONE

20c. TIME OF INJURY: Hour a.m. p.m. / Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from. Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

ACTUAL SIGNATURE: Philip W. Heuman M.D. ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED: FEB 5, 1961

EXAMINER'S NAME (Type): PHILIP W. HEUMAN, M.D. Address (Street, city, town, or county): 302 HICKORY, BEL AIR

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: 2/9/61

22c. NAME OF CEMETERY OR CREMATORY: Nassau Hills

22d. LOCATION (City or town) (State): New York

23. FUNERAL DIRECTOR: Funeral Dir. Hamde Funeral Home

ADDRESS

24a. REC'D BY REGISTRAR DATE: FEB 7 '61

24b. REGISTRAR'S SIGNATURE: Arthur J. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any d... nec... please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
SM 9 60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1978 CERTIFICATE OF DEATH

01954

1. PLACE OF DEATH
a. COUNTY: HARFORD
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE de GRACE
c. LENGTH OF STAY IN 1b: MARYLAND 10 MIN.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HARFORD MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CECIL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): AIKEN
d. STREET ADDRESS: AVE, PERRYVILLE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HARRY Middle S. Last McMULLEN

4. DATE OF DEATH: Month FEBRUARY Day 24 Year 1961

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: APR. 29, 1902

9. AGE (In years last birthday): 58 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ENGINEER

10b. KIND OF BUSINESS OR INDUSTRY: U.S NAVY

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: ARTHUR McMULLEN

14. MOTHER'S MAIDEN NAME: Marion SHARPLESS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): YES WW 2

16. SOCIAL SECURITY NO.: 212-30-3516

17. INFORMANT Address: Elva D. McMullen, Perryville, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 1/2 hr.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from ..... 19..... to ..... 19....., that (I) (we) last saw the deceased alive on ..... 19..., and that death occured at 3:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Clarence I. Benson MD Deputy Coroner
Gerald C. Palmer MD Deputy Coroner

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Clarence I. Benson M.D. Medical Examiner
Gerald C. Palmer Harford County, Md.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22d. ADDRESS: Port Deposit, Md.
Bel Air, Md.

23a. BURIAL, CREMATION, REMOVAL: (Specify) Burial

23b. DATE THEREOF: 2-26-1961

23c. NAME OF CEMETERY OR CREMATORY: Principio Cem.

23d. LOCATION (City, town or county) (State): Principio Furnace, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Lee A Patterson & Son

ADDRESS: Perryville, Md.

25a. REC'D BY REGISTRAR DATE: FEB 27 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS A15 (4)
15M 9/60

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1979 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0195

1. PLACE OF DEATH
a. COUNTY: Harford
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewood
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Wilougbby Beach Road

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewood
d. STREET ADDRESS: Wilougbby Beach Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robert; Middle: ; Last: Mercer

4. DATE OF DEATH: Month: February; Day: 5; Year: 1961

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Dec 28 879

9. AGE (In years) (If UNDER 1 YEAR last birthday) yrs.: 81
IF UNDER 1 YEAR Months: ; Days: ; IF UNDER 24 HRS Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Miner

10b. KIND OF BUSINESS OR INDUSTRY: Coal

11. BIRTHPLACE (State or foreign country): Va.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.,

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): unknown

16. SOCIAL SECURITY NO.: 578-16-2598

17. INFORMANT: Address: Harford Co., Welfare Board, Bel Air, Md'.,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic CV disease
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer M.D.

EXAMINER'S NAME (Type): Gerald C Palmer M.D.

CHIEF MEDICAL EXAMINER ☐ Bel Air, Md
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)

DATE SIGNED: 2-8-61

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: 3-2-61

22c. NAME OF CEMETERY OR CREMATORY: U. of Md. Med. School

22d. LOCATION (City, town, or country) (State): Baltimore, Md.

23. FUNERAL DIRECTOR: Howard E McComas Jr

ADDRESS: Abingdon, Md.,

24a. REC'D BY REGISTRAR DATE: MAR 10 '61

24b. REGISTRAR'S SIGNATURE: Clinton L. Evans

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1980 0195

1. PLACE OF DEATH
a. COUNTY: Harford
MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
c LENGTH OF STAY IN 1b: 5 months
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION: US Army Hospital, Aberdeen Proving Ground, Md

2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Delaware
b. COUNTY: New Castle
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): New Castle
d. STREET ADDRESS: 70 University Avenue Wilmington Manor Gardens
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HARRY Middle JAMES Last MILLS

4. DATE OF DEATH: Month February Day 2 Year 19 61

5 SEX: Male
6 COLOR OR RACE: White
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: February 9, 1886
9 AGE last birthday: 74 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Soldier-M/Sgt (Retired)
10b KIND OF BUSINESS OR INDUSTRY: US Army Retired
11. BIRTHPLACE (State or foreign country): Canada
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Henry James Mills (212-26-2984)
14 MOTHER'S MAIDEN NAME: Elizbeth Margaret Curtis

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
If yes, give dates: 30 Oct 1917 to 30 Apr 1939
16 SOCIAL SECURITY NO.: 212-26-2984 ~~215-00-5339~~
17 INFORMANT: Grace May Mills (Wife)
Address: Same as item 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 13 Sep 60
DUE TO
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)

199.2

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 I certify that ☒ (this hospital) attended the deceased from September 13 60 to February 2, 19 61 that ☒ (we) last saw the deceased alive on February 2 19 61 and that death occurred at 7:00 PM from the causes and on the date stated above

22a SIGNATURE: Mark Eisenstein M D
ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒
22b DATE SIGNED: 2 Feb 61
22c PHYSICIAN'S NAME (Type): MARK EISENSTEIN Capt MC
22d ADDRESS: US Army Hospital Aberdeen Proving Ground, Maryland

23a BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE THEREOF: Feb. 7, 1961
23c NAME OF CEMETERY OR CREMATORY: Post Cemetery
23d LOCATION (City, town, or county) (State): Army Chemical Center Md.,

24a FUNERAL DIRECTOR'S SIGNATURE: Howard N. Miller Jr.
ADDRESS: Abingdon Md.,
25a REC'D BY REGISTRAR DATE: FEB 8 '61
25b REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1981 CERTIFICATE OF DEATH

Reg. Dist. No. 01957

1 PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Joppa
c. LENGTH OF STAY IN 1b: 30 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Joppa
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: L. — Last: Payne

4. DATE OF DEATH: Month: Feb. — Day: 15 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 20, 1875

9. AGE (In years last birthday): 85 yrs

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Owner

11. BIRTHPLACE (State or foreign country): Maryland.

12. CITIZEN OF WHAT COUNTRY? U.S.A.,

13. FATHER'S NAME: Levin Payne

14. MOTHER'S MAIDEN NAME: Sarah Henderson

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO: 218-14-4832

17. INFORMANT: Virginia B. Payne, — Address: Joppa, Md.,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Toxemia- Gangrene right arm from Thrombosis
DUE TO (b): Brachial artery.
DUE TO (c): Chronic Cardio Vascular Disease.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb 3, 1957, to Feb. 14, 1961, that I last saw the deceased alive on Feb 13, 1961, and that death occurred at 3:20 A. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Willard P. Hudson M.D — ADDRESS (Street, city or town, state): Forest Hill, Md. — DATE SIGNED:

PHYSICIAN'S NAME (Type): Willard P. Hudson M.D. — Forest Hill, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Feb. 17, 1961

22c. NAME OF CEMETERY OR CREMATORY: Trinity Lutheran

22d. LOCATION (City, town, or county) (State): Joppa, Harford, Maryland.

23. FUNERAL DIRECTOR'S SIGNATURE: Howard K. McComas, Jr. — ADDRESS: Abingdon, Md.,

24a. REC'D BY REGISTRAR DATE: FEB 20 '61

24b. REGISTRAR'S SIGNATURE: Clinton L. Hand

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1982 CERTIFICATE OF DEATH

01958

Reg. Dist. No.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH

COUNTY: Harford — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Federal Hill

LENGTH OF STAY (in this place): 63 years

HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: Maryland COUNTY: Harford

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Rocks

STREET ADDRESS (If rural give location): Federal Hill

3. NAME OF DECEASED (Type or Print): (First) Dora (Middle) Faidley (Last) Phillips

4. DATE OF DEATH (Month) Feb. (Day) 28 (Year) 1961

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	Dec. 1, 1865	95 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	Gallatin, Tenn.	USA

13. FATHER'S NAME: Charles F. Faidley

14. MOTHER'S MAIDEN NAME: Susanna Fothergill

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
No	———	213-38-9085	Mrs. Robert Foard Rocks, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

1 IX IMMEDIATE CAUSE (A) Hydronephrosis, Bilateral — INTERVAL BETWEEN ONSET AND DEATH: 10 years.

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Arteriosclerotic Cardio-Vascular Disease — 15 years.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/25/57, to 2/27/61, that I last saw the deceased alive on 2/27/61, and that death occurred at 12:30 M, from the causes and on the date stated above.

SIGNATURE Robert Barthel M.D. — ADDRESS (Street, city, town, state) Forest Hill, Maryland — DATE SIGNED 2/28/61

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	3/2/1961	Jarrettsville	Jarrettsville, Md.

24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
DATE MAR 3 '61	[illegible]	Charles E. Rusty Jarrettsville, Md.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1983 Item 9 filed 2-9-61 et 0195

1 PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Forest Hill
c. LENGTH OF STAY IN 1b: 55 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Forest Hill
d. STREET ADDRESS: Cooptown
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First GEORGE Middle Barclay Last PHILLIPS

4. DATE OF DEATH: Month February Day 4 Year 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8 DATE OF BIRTH: Jan. 3, 1884

9. AGE (In years last birthday): 77 yrs

IF UNDER 1 YEAR: Months ____ Days ____ IF UNDER 24 HRS: Hours ____ Min ____

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer owner

10b KIND OF BUSINESS OR INDUSTRY: Gen. Farming

11. BIRTHPLACE (State or foreign country): Nottingham, Pa.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: F. Harvey Phillips

14 MOTHER'S MAIDEN NAME: Catherine Hetherington

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No ----

16. SOCIAL SECURITY NO: ----

17. INFORMANT Address: Miss. Kathleen Phillips Forest Hill Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

422.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Ch. Cardio-vascular Disease — ?

DUE TO

(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19 WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Hour a m p. m. Month, Day, Year 19

20d INJURY OCCURRED While at work [ ] Not while at work [ ]

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from May 1958 to Feb. 4, 1961, that (I) (we) last saw the deceased alive on Feb. 1 1961, and that death occurred at 2:30, from the causes and on the date stated above.

22a SIGNATURE: Willard P. Hudson M.D.

ATTENDING PHYS [ ] MED DIRECTOR [ ] STAFF PHYS [ ]

22b DATE SIGNED: 2/4/61

22c. PHYSICIAN'S NAME (Type): Willard P. Hudson, M.D.

22d. ADDRESS: ForestHill, Maryland

23a BURIAL CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 2/7/1961

23c NAME OF CEMETERY OR CREMATORY: Old Brick Baptist

23d LOCATION (City, town, or county) (State): Jarrettsville Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Charles E. Kurtz ADDRESS: Jarrettsville Md.

25a. REC'D BY REGISTRAR DATE FEB 7 '61

25b REGISTRAR'S SIGNATURE: Calvin S. Krauss

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by attending physician or hospital. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 1SM 9/59

Item 18 Film 284 4-18-61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1984 — 01960

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre-de-Grace
c. LENGTH OF STAY IN 1b: 12 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Md — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Darlington
d. STREET ADDRESS: Box 105
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Donald — Middle: L. — Last: Presberry

4. DATE OF DEATH: Month: February — Day: 9 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1/28/61

9. AGE (In years last birthday): ___ yrs. — IF UNDER 1 YEAR: Months 1/2 — Days ___ — IF UNDER 24 HRS.: Hours ___ — Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Baby

10b. KIND OF BUSINESS OR INDUSTRY: Baby

11. BIRTHPLACE (County & State, or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Howard C. Presberry

14. MOTHER'S MAIDEN NAME: Doris C. Jolliner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Howard C Presberry Darlington Md

Address: Box 105

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): [illegible]

DUE TO: Renal-vein Thrombosis, bilateral

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b): [illegible]

DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1.a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Jan 28, 1961, to Feb. 9, 1961, that (I) (we) last saw the deceased alive on Feb. 9. 1961., and that death occured at 5:25 PM, from the causes and on the date stated above.

22a. SIGNATURE: George T. Stansbury, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2/11/61

22c. PHYSICIAN'S NAME (Type): George T. Stansbury

22d. ADDRESS: 569 Revolution St. Havre de Grace, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/11/61

23c. NAME OF CEMETERY OR CREMATORY: Berkley Cemetery

23d. LOCATION (City, town or county) (State): Harlington Md

24. FUNERAL DIRECTOR'S SIGNATURE: Elmer E Bullock — ADDRESS: Havre de Grace

25a. REC'D BY REGISTRAR DATE: FEB 15 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed as to cause of death, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
ISM 9/60

1

FOR STATE HEALTH DEPT.

TO DEPUTY MED. EXAMINER: This certificate should be executed within 24 hours after death. If any of the items is not known, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1985 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 2 Film 201 2-16-61 et 0196

1 PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Fountain Green Road

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air R.D #2
d. STREET ADDRESS: Fountain Green Road
IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First Hall Middle E Last Rogers
4. DATE OF DEATH: Month February Day 4 Year 19 61

5 SEX: M
6 COLOR OR RACE: W
7. MARRIED [ ] NEVER MARR.ED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: June 21, 1903
9 AGE (In years last birthday): 57 yrs.
IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Store Owner (Ret.)
10b. KIND OF BUSINESS OR INDUSTRY: Merchandise
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Wallace Rogers
14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 217-01-3959
17. INFORMANT: Charles W. Rogers Address 110 Baltimore St Aberdeen, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): R S W Centrum
9767
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.): Shot self
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year: 2-27-1961
20d. INJURY OCCURRED While at work [ ] Not While at work [X]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) (County) (State): Bel Air Harford Md.

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [ ], and in my opinion death resulted from. Natural causes [ ], Accident [ ], Suicide [X], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Gerald C Palmer M D
EXAMINER'S NAME (Type): Gerald C Palmer M D
CHIEF MEDICAL EXAMINER [ ] Bel Air Md
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
Address (Street, city, town, or county)
DATE SIGNED: 2-4-61

22a. BURIAL, CREMATION REMOVAL (Specify): Burial
22b DATE THEREOF: 2/11/61
22c. NAME OF CEMETERY OR CREMATORY: Smith Chapel Cemetery
22d. LOCATION (City, town, or country) (State): R.D. 2, Aberdeen Md.

23. FUNERAL DIRECTOR ADDRESS: Tarring Funeral Home Aberdeen, Md.
John G. Tarring
24a. REC'D BY REGISTRAR DATE: FEB 7 '61
24b. REGISTRAR'S SIGNATURE: Clifton S. Evans

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1986 01962

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen Proving Ground
c. LENGTH OF STAY IN 1b: 22 hours
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Army Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Colora Rural
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First ELSENA Middle FAYE Last SHIRES

4. DATE OF DEATH: Month February Day 15 Year 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: February 14, 1961

9. AGE (In years last birthday): yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours 22 Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): N/A

10b. KIND OF BUSINESS OR INDUSTRY: N/A

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: WILLIAM FAY SHIRES

14. MOTHER'S MAIDEN NAME: RUTH ELSIE BLAKELEY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): N/A (If yes give war or dates of service): N/A

16. SOCIAL SECURITY NO.: N/A

17. INFORMANT Address: Mrs. Ruth Shires (Mother) Colora, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity, severe — INTERVAL BETWEEN ONSET AND DEATH: 22 hours
DUE TO: (Approx 6 months gestation)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 14 Feb 1961 to 15 Feb 1961, that (I) (we) last saw the deceased alive on 15 Feb 1961 and that death occurred at 9:25 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Mark Eisenstein M.D. — ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS. ☒ — 22b. DATE SIGNED: February 15, 1961

22c. PHYSICIAN'S NAME (Type): MARK EISENSTEIN, Captain, MC

22d. ADDRESS: U.S. ARMY HOSPITAL, Aberdeen Proving Ground, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 2/18/60 — 23c. NAME OF CEMETERY OR CREMATORY: West Nottingham — 23d. LOCATION (City, town or county): Colora (State): Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Vernon E. McMellon — ADDRESS: Rising Sun Md.

25a. REC'D BY REGISTRAR DATE: FEB 20 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1987 CERTIFICATE OF DEATH

Reg. Dist. No. 01963

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen (Rural)
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: R.D. #2,

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Aberdeen (Rural)
d. STREET ADDRESS: R.D. #2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JAMES — Middle M. — Last SIMMONS
4. DATE OF DEATH: Month February — Day 11 — Year 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Feb. 29, 1880
9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic (Ret.)
10b. KIND OF BUSINESS OR INDUSTRY: Ord.Dept. U.S. Govt.
11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Simmons
14. MOTHER'S MAIDEN NAME: Sarah Hanks

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: T. Cordie Simmons, Address R.D. #1 Aberdeen, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Congestive Heart Failure and	3 mo
331 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)	Multiple small Cerebrovascular Accidents	4 yr
DUE TO (c)	Generalized Arteriosclerosis	10 yrs

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from June 12, 19 50, to Feb 11, 19 61, that I last saw the deceased alive on Feb. 8, 1961, and that death occurred at 9:50 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Dudley Phillips M.D. — ADDRESS (Street, city or town, state): Darlington, Md. — DATE SIGNED

PHYSICIAN'S NAME (Type): Dudley Phillips, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/14/61
22c. NAME OF CEMETERY OR CREMATORY: Mt. Zion Cemetery
22d LOCATION (City, town, or county) (State): R.D. Bel Air, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: John F. Tarring — ADDRESS: Tarring Funeral Home Aberdeen, Md.
24a. REC'D BY REGISTRAR DATE: FEB 15 '61
24b. REGISTRAR'S SIGNATURE: Arthur L. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1988 CERTIFICATE OF DEATH

Reg. Dist. No. 01964

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL - FOREST HILL
c. LENGTH OF STAY IN 1b: 3 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WALTER'S MILL ROAD

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL - FOREST HILL
d. STREET ADDRESS: WALTER'S MILL ROAD
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First JOHN — Middle LESTER — Last SMITH

4. DATE OF DEATH: Month FEBRUARY — Day 8 — Year 1961

5. SEX: MALE

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: AUGUST 24, 1891

9. AGE (In years last birthday): 69 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER

10b. KIND OF BUSINESS OR INDUSTRY: Owner

11. BIRTHPLACE (State or foreign country): NORTH CAROLINA

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Lee SMITH

14. MOTHER'S MAIDEN NAME: ELLEN JOHNSON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 236-07-1159

17. INFORMANT: Mrs. Lytha Smith (wife) — Address: FOREST HILL, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 3 months

4 2 8 . 1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Arteriosclerotic cardiovascular disease — 6 years

DUE TO (c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): BRONCHopneumonia, Recurrent

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from September 25, 1954, to February 8, 1961, that I last saw the deceased alive on February 7, 1961, and that death occurred at 6:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Paul S. Stonesifer Jr. M.D. — ADDRESS (Street, city or town, state): 115 Fulford Ave. — DATE SIGNED: 2/8/61

PHYSICIAN'S NAME (Type): PAUL S. STONESIFER JR. — Bel Air, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Feb. 11, 1961

22c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens

22d. LOCATION (City, town, or county) (State): Bel Air, Harford, Md.,

23. FUNERAL DIRECTOR'S SIGNATURE: Howard K. McComas Jr. — ADDRESS: Abingdon, Md.,

24a. REC'D BY REGISTRAR DATE: FEB 14 '61

24b REGISTRAR'S SIGNATURE: Lillian L. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1989 — 0196

1. PLACE OF DEATH
a. COUNTY: Harford — b. STATE: MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre-de-Grace
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md — b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
d. STREET ADDRESS: 220 Schmechel St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lester Louis — Middle: — Last: Smith.

4. DATE OF DEATH: Month: 2 — Day: 12 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2-10-61

9. AGE (In years last birthday): — yrs. — IF UNDER 1 YEAR: Months: — Days: 2 — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Infant.

10b. KIND OF BUSINESS OR INDUSTRY: Infant.

11. BIRTHPLACE (County & State, or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Lester Smith.

14. MOTHER'S MAIDEN NAME: Helen Snyder.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Lester Louis Smith Jr. — Address: 220 Schmechel St. Aberdeen Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Hepatic failure

DUE TO (b): Congenital atresia bile ducts

DUE TO (c): Maldevelopment, congenital

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 12 hours.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f (City or town) — (County) — (State)

21. **I certify** that (I) (this hospital) attended the deceased from 2/10, 1961 to 2/12, 1961, that (I) (we) last saw the deceased alive on February 12 1961, and that death occured at 10 A.M. from the causes and on the date stated above.

22a. SIGNATURE: William M. Lee MD — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2/13/61

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 2/14/61

23c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gdns. — 23d. LOCATION (City, town or county) (State): Bel Air Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: John G. Tarring — ADDRESS: Aberdeen. Maryland.

25a. REC'D BY REGISTRAR DATE: FEB 15 '61 — 25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cardboard papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 1966

1990

1. PLACE OF DEATH
a. COUNTY Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Street
c. LENGTH OF STAY IN 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Street

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Doyle Road
e. STREET ADDRESS Doyle Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Middle Last: Malisha Darlene Teague
4. DATE OF DEATH Month February Day 6 Year 1961

5. SEX F
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH JAN. 25, 1961
9. AGE (In years last birthday) yrs.
IF UNDER 1 YEAR: Months — Days 12
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) HAVRE DE GRACE, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME CURTIS TEAGUE
14. MOTHER'S MAIDEN NAME KATHRYN MAINE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address: CURTIS TEAGUE, STREET, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
776X
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE Gerald C Palmer M.D.
EXAMINER'S NAME (Type) Gerald C Palmer M.D.
CHIEF MEDICAL EXAMINER ☐ Bel Air, Md
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 2-6-61

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF 2-8-1961
22c. NAME OF CEMETERY OR ~~CREMATORY~~ EMORY
22d. LOCATION (City, town, or county) (State) STREET, Md.

23. FUNERAL DIRECTOR'S SIGNATURE John H. Hopkins
ADDRESS Delta, Pa.
24a. REC'D BY REGISTRAR DATE FEB 8 '61
24b. REGISTRAR'S SIGNATURE C Vernon L Kaufman

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, giving the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Pages 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

4-1213 XVI

1

FOR STATE HEALTH DEPT.

TO DEPUTY MED EXAMINER: This certificate should be executed within 24 hours after death. If any cause is not known, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME 5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1991 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01967

1. PLACE OF DEATH
a. COUNTY Harford MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air
c. LENGTH OF STAY IN 1b 40 Years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 122 Alexanne St

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE Md b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air 22
d. STREET ADDRESS 122 Alexanne St e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Ella Middle: Wright Last: Thomas

4. DATE OF DEATH Month: Feb Day: 15 Year: 1961

5. SEX F

6. COLOR OR RACE C

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH 5-3-76

9. AGE (In years last birthday) 84 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY Homemaker

11. BIRTHPLACE (State or foreign country) Md

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Unknown Wright

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT West Thomas Address Bel Air Md RD 3 Box 322A

(I)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemiplegia

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Gerald C Palmer M D

CHIEF MEDICAL EXAMINER ☐ Bel Air Md

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type) Gerald C Palmer M D

Address (Street, city, town, or county)

DATE SIGNED 2-15-61

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF Feby 17/61

22c. NAME OF CEMETERY OR CREMATORY Hendon's Hill

22d. LOCATION (City, town, or country) Bel Air (State) Harford Md

23. FUNERAL DIRECTOR Joseph T Slater ADDRESS Bel Air Md

24a. REC'D BY REGISTRAR DATE FEB 17 '61

24b. REGISTRAR'S SIGNATURE Arthur S. Krauss

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1992 Reg. Dist. No. 01968

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace (Rural)
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): R.D. Rivers Farm

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace (Rural)
d. STREET ADDRESS: R.D.
e. IS RESIDENCE ON A FARM? YES XX NO ☐

3. NAME OF DECEASED (Type or print): First JAMES — Middle H. — Last THOMPSON

4. DATE OF DEATH: Month February — Day 22 — Year 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: Oct. 27, 1881

9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook Retired

10b. KIND OF BUSINESS OR INDUSTRY: B&O R.R.

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: William H. Thompson

14. MOTHER'S MAIDEN NAME: Susie Cullum

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214/14/4937

17. INFORMANT: Clem Thompson, Havre de Grace, Md. — Address: R.D.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Intherosclerosis — INTERVAL BETWEEN ONSET AND DEATH:

4500

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour — a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL Gerald C Palmer M.D.

CHIEF MEDICAL EXAMINER ☐ BelAir, W. DATE SIGNED

ASSISTANT MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type): Gerald C. Palmer, M.D. — DEPUTY MEDICAL EXAMINER ☒ 2-22-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

22b. DATE THEREOF: 2/24/61

22c. NAME OF CEMETERY OR CREMATORY: Greenmount Cemetery

22d. LOCATION (City, town, or county) (State): Balto. Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: John G. Young — ADDRESS: Aberdeen Maryland

24a. REC'D BY REGISTRAR DATE: FEB 27 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay in excess of 4 days occurs in completing the ward "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director for execution. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1993

Reg. Dist. No. 0196

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Oakington
c. LENGTH OF STAY IN 1b: 70 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: —

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Oakington
d. STREET ADDRESS: —
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Millard Middle E. Last Tydings

4. DATE OF DEATH: Month 2 Day 9 Year 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4/6/1890

9. AGE (In years last birthday): 70 yrs

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lyricist Ex. U.S. Rep.

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): Harford County

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Millard F. Tydings

14. MOTHER'S MAIDEN NAME: Mary O'Neill

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): W. W.

16. SOCIAL SECURITY NO: Unknown

17. INFORMANT: Eleanor D. Tydings — Address: Oakington, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Generalized Circulatory Failure — INTERVAL BETWEEN ONSET AND DEATH: 12 hours

162.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Pneumonia, left lower lobe — 5 days

DUE TO (c): Bronchogenic Carcinoma — 7 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2-4-, 1961, to 2-9-, 1961, that I last saw the deceased alive on 2-9-, 1961, and that death occurred at 5:30 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Peter P. Redman, M.D.

ADDRESS (Street, city or town, state): 8 [illegible] St. Aberdeen, Md.

DATE SIGNED: 2-11-61

PHYSICIAN'S NAME (Type): Peter P. Redman M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: 2/12/61

22c. NAME OF CEMETERY OR CREMATORY: Angel Hill

22d. LOCATION (City, town, or county) (State): Havre de Grace Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Funeral Dir. — ADDRESS: Havre de Grace, Md.

24a. RECD. BY REGISTRAR DATE: FEB 14 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1994 — 01970

1. **PLACE OF DEATH**
   a. COUNTY: Harford
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Darlington R.F.D.
   c. LENGTH OF STAY IN 1b: MARYLAND
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. **USUAL RESIDENCE** (Where deceased lived, If inst tution, Residence before adm ssion)
   a. STATE: Md
   b. COUNTY: Harford
   c. CITY OR TOWN (If outside corporate l m ts, write RURAL and give nearest town): Darlington R. F. D.
   d. STREET ADDRESS:
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First: David — Middle: E — Last: Wallace

4. **DATE OF DEATH**: Month: Feb. — Day: 23 — Year: 19 61

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 2, 1906

9. AGE (In years last birthday): 54 yrs.

IF UNDER 1 YEAR: Months | Days

IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give k nd of work done during most of working l fe, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Senator

11. BIRTHPLACE (County & State, or foreign country): Harford Co. Md U. S. A.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Joseph Wallace

14. MOTHER'S MAIDEN NAME: Elizabeth Wallace

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No

16. SOCIAL SECURITY NO: 218-28-6605

17. INFORMANT: Address: Elizabeth Wallace

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Failure
DUE TO (b): F 43X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Hypertensive-Arterio Sclerotic Heart disease

INTERVAL BETWEEN ONSET AND DEATH

PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.: Pneumonitis with Poss. Pulmonary Neoplasm

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of Item 18)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 9/16 1960, to 2/23 1961, that (I) (we) last saw the deceased alive on 2/21 19 61, and that death occured at 11:00 AM, from the causes and on the date stated above.

22a. SIGNATURE: George T. Stansbury, M.D.

ATTEND NG PHYS ☐ MED. D RECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 2/27/61

22c. PHYSICIAN S NAME (Type): George T. Stansbury

22d. ADDRESS: 569 Revolution St. Havre de Grace, Md.

23a. BURIAL, ~~CREMATION~~, ~~REMOVAL~~ (Specify)

23b. DATE THEREOF: Feb 28, 1961

23c. NAME OF CEMETERY OR CREMATORY: Cedars

23d. LOCAT.ON (City, town or county): Harford Co.

(State): Md.

24 FUNERAL DIRECTOR'S SIGNATURE: H. S. Bailey

ADDRESS: Darlington Md.

25a. REC'D BY REGISTRAR: DATE MAR 3 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1995 Reg. Dist. No. 0197

1. PLACE OF DEATH

COUNTY Harford — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air Rural

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS Walters Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Md COUNTY Harford

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel-Air Rural

STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) Bessie (Middle) Lee (Last) Walters

4. DATE OF DEATH (Month) February (Day) 26, (Year) 1961

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
F	White	Widowed	Jan. 3 1880	81 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Operator Waitress	Nursing Home	Harford Co Md	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
James Temple	Cornelia Whitaker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
No	No	214-34-4062	Edward [illegible]

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 7 days

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B)

DUE TO (C) Chronic Cardio-vascular Disease — ?

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Diabetes Mellitus — ?

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from January, 1956, to Feb. 26, 1961, that I last saw the deceased alive on Feb. 25, 1961, and that death occurred at 3:25 PM, from the causes and on the date stated above.

SIGNATURE Willard P. Hudson M.D. — ADDRESS (Street, city, town, state) Forest Hill, Md. — DATE SIGNED Feb. 26, 1961

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
	March 1, 1961	Mt Tabor	Harford Co Md

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
Mar 3 '61	Orthea L. Kirby	H. B. Bailey	Darlington Md

1 12-30-69

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1996 01972

(M)

1. PLACE OF DEATH a. COUNTY Harford MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace
c. LENGTH OF STAY IN 1b 37 Days.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Bush Chapel RD
d. STREET ADDRESS 1 Aberdeen R.F.D. #1.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

071

3. NAME OF DECEASED (Type or print) First: Ida Middle: M Last: Warfield
4. DATE OF DEATH Month: February Day: 6 Year: 1961
5. SEX Female
6. COLOR OR RACE Colored
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH June 9th 1893
9. AGE (In years last birthday) 67 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

(I)

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic Work
10b. KIND OF BUSINESS OR INDUSTRY Homes.
11. BIRTHPLACE (State or foreign country) Maryland.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME Mary Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 214-12-0203
17. INFORMANT Douglas E. Stansbury (Son) Address Aberdeen Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b) Diabetes Mellitus

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260X

DUE TO (c) Hypertensive Cardio renal Disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12/3 1960, to 2/6 1961, that (I) (we) last saw the deceased alive on February 6 1961, and that death occurred at 11:05 A.M., from the causes and on the date stated above.

22a. SIGNATURE George T. Stansbury, M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED 2/7/61
22c. PHYSICIAN'S NAME (Type) George T. Stansbury
22d. ADDRESS 569 Revolution St. Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 2/10/1961
23c. NAME OF CEMETERY OR CREMATORY Union M.E. Cemetery
23d. LOCATION (City, town, or county) (State) Aberdeen. Maryland.

24. FUNERAL DIRECTOR'S SIGNATURE John G. Farring — ADDRESS Aberdeen. Md.
25a. REC'D BY REGISTRAR DATE FEB 10 '61
25b. REGISTRAR'S SIGNATURE Arthur S. Evans

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

2

1

BR

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1997 CERTIFICATE OF DEATH

Reg. Dist. No. 01973

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: RD1 Box 220

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Aberdeen
d. STREET ADDRESS: RD1 Box 220
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First VERNON Middle ARMSTRONG Last WOODS

4. DATE OF DEATH: Month February Day 9 Year 1961

5. SEX: Male
6. COLOR OR RACE: Caucasian
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10/31/08
9. AGE (In years last birthday): 52 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY: Retired US Navy
11. BIRTHPLACE (State or foreign country): Wyoming
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Samuel Woods
14. MOTHER'S MAIDEN NAME: Bertha Bennett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Yes 23 yrs
16. SOCIAL SECURITY NO.:
17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	CONGESTIVE HEART FAILURE	4 DAYS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)	AURICULAR FIBRILLATION	3 MOS
DUE TO (c)	PULMONARY FIBROSIS	3 YRS

525 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from APRIL 22, 1960, to Feb 8, 1961, that I last saw the deceased alive on Feb 6, 1961, and that death occurred at 3:45 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Leonard Niesenbaum M.D. ADDRESS (Street, city or town, state): USNTC Bainbridge MD. DATE SIGNED: 10 Feb 61

PHYSICIAN'S NAME (Type): LEONARD NIESENBAUM LT MEDICAL CORPS USNTC BAINBRIDGE MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/11/1961
22c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens.
22d. LOCATION (City, town, or county) (State): Bel Air, Harford Co. Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: John G. Darning ADDRESS: Aberdeen - Maryland
24a. REC'D BY REGISTRAR DATE: FEB 14 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55